Standard Response to Verification of Employment

Employers will provide requested information normally maintained on employees. If additional information not listed on this form is needed, please contact the employer.

PAYROLL SECTION - Employee Personal Information

Full Name: _____
Last *First* *M.I.*

Residential Address, if known: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Mailing Address, if known: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

E-mail Address, if known: _____

Social Security Number: _____ Date of Birth: _____

Employer and Job Information

Employment Status: ☐ Currently Employed ☐ Terminated ☐ Never Employed

Title: _____ Dates of Employment: _____

Employer Name: _____ Employer Address: _____

Employer Phone Number: _____ Employer Fax Number: _____

Federal EIN: _____

Full/Part Time or Seasonal: ☐ Full Time ☐ Part Time ☐ Seasonal

Begin Date: _____ End Date: _____

Return to Work Date: _____

Employee Work Site or Location: _____

Termination Reason: ☐ Voluntary ☐ Involuntary

Wage Information

Pay Cycle/Frequency: _____ Rate of Pay: $ _____

Gross Pay Per Period: $ _____ Net Disposable Pay Per Period: $ _____

Current Year-to-Date Earnings: $ _____

Previous Calendar Year Earnings: $_____

Union Name: _____ Local Number: _____

Mandatory Union Dues: $_____ Mandatory Retirement: $_____

Tax Filing Status: ☐ Single ☐ Married ☐ Head of Household

Number of Dependents: _____

Workers' Compensation: ☐ Yes ☐ No

Name of Workers' Compensation
Company and Contact Information: _____

_____

Certification Information

Completed by:

Employer Name (Employee's Employer): _____

Name: _____

Title: _____

Signature: _____

Date: _____

Phone Number: _____

If additional information is needed, please contact the person listed above.

HEALTH INSURANCE SECTION - Employee Personal Information

Full Name: _____

Last *First* *M.I.*

Last 4 digits of Social Security Number: _____

Health Insurance Availability

Does the employer offer health insurance? ☐ Yes ☐ No

If not available currently to the employee, when will it be available? _____

Is health insurance available for dependents or spouse? ☐ Yes ☐ No

Is this paid by: ☐ Payroll Deduction ☐ Payment

Has the employee enrolled self and/or dependents? ☐ Self ☐ Dependents

Medical Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

_____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: $_____

Policy Group Name/Number: _____ Cost for Listed Children: $_____

Cost for Employee/Family: $_____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Dental Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

_____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: $_____

Policy Group Name/Number: _____ Cost for Listed Children: $_____

Cost for Employee/Family: $_____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Vision Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

_____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: $ _____

Policy Group Name/Number: _____ Cost for Listed Children: $ _____

Cost for Employee/Family: $ _____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Prescription Drug Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

_____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: $ _____

Policy Group Name/Number: _____ Cost for Listed Children: $ _____

Cost for Employee/Family: $ _____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Mental Health Insurance

Insurance Provider's Name: _____

Insurance Provider's Address: _____

_____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: $ _____

Policy Group Name/Number: _____ Cost for Listed Children: $ _____

Cost for Employee/Family: $ _____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Other Health Insurance(specify type here):

Insurance Provider's Name: _____

Insurance Provider's Address: _____

_____

Insurance Provider's Phone: _____ Fax: _____

Policy/Contract Number: _____ Cost for Employee Coverage: $ _____

Policy Group Name/Number: _____ Cost for Listed Children: $ _____

Cost for Employee/Family: $ _____

Cost Frequency: _____

Complete the following information for each dependent:

Name (Last, First, Middle)	Social Security Number	Date of Birth	Group Number	Policy Number	Start Date	End Date

Certification Information

Completed by:

Name and Title: _____

Company Name: _____

Signature: _____

Date: _____ Phone Number: _____